

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 11, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

A revision to Medicaid Services Manual (MSM) Chapter 1000 is being proposed to clarify coverage and limitations regarding initial diagnostic services when required for prior authorization of Orthodontia treatment. The codes include D0470-diagnostic cast, D0330-panoramic x-rays, and D0350-diagnostic photographs. These diagnostic services are considered to be Orthodontia services only for reimbursement to Provider Type 22 Dental with specialty 079-Orthodontist.

These changes are effective February 12, 2016.

MATERIAL TRANSMITTED

MTL 03/16
CHAPTER 1000 - DENTAL

MATERIAL SUPERSEDED

MTL 14/15
CHAPTER 1000 - DENTAL

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8	Orthodontics (D8000-D8999)	Added clarification of coverage of Current Dental Terminology (CDT) codes outside D8000 series that are considered part of Orthodontia treatment only when required for Prior Authorization (PA) and provided by an Orthodontist.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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1000 DENTAL

INTRODUCTION

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. Dental services provided shall maintain a high standard of quality and shall be provided within the coverage and limitation guidelines outlined in this Chapter. All Medicaid policies and requirements, (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Manual Chapter 1000 are the same for NCU.

All providers participating in the Medicaid program must provide services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available through Medicaid's Quality Improvement Organization (QIO) like vendor.

Nevada Medicaid provides dental services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. For Medicaid-eligible adults age 21 years and older, dental services are an optional service as identified in this chapter and the Billing Guide documents located at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist.

Individuals under Age 21

Through the EPSDT benefits, individuals under the age of 21, receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services, including orthodontia when medically necessary and pre-approved by the Nevada Medicaid QIO-like vendor. The EPSDT screening provider may refer children for dental services. However, such a referral is not necessary if the parent otherwise elects to contact a Medicaid dental provider. The local Medicaid District Office can direct the parent/guardian to local dental providers.

Individuals age 21 and older

Dental services for Medicaid-eligible adults who qualify for full benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations.

Pregnancy Related Services

Nevada Medicaid offers expanded dental services in addition to the adult dental services for Medicaid-eligible pregnant women. These expanded pregnancy related services require prior authorization.

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1001 AUTHORITY

Nevada Revised Statute (NRS) 631- Dentistry and Dental Hygiene.

The State Plan of Nevada describes the amount, duration and scope of dental care and services provided to the categorically needy in Attachments 3.1-A 10 and 3.1-A 12b.

The Centers for Medicare and Medicaid Services (CMS) state that necessary and essential dental services are mandatory for all eligible Medicaid children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under the Social Security Act 1905(r)(5). The Nevada EPSDT program provides children with services that are in addition to those available to adult recipients as cited in the Code of Federal Regulations (CFR) Section 441.56.

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1003 NEVADA MEDICAID POLICY

Reference the Coverage, Limitations, and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist Billing Guide for a list of CDT codes detailing prior authorization requirements and service limitations.

1003.1 DIAGNOSTIC AND PREVENTIVE SERVICES (D0100-D1999)

The branch of dentistry used to identify and prevent dental disorders and disease.

The United States Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Nevada Medicaid lists these recommendations in the Medicaid Services Manual (MSM) Chapter 600, Attachment A.

The USPSTF recommends application of fluoride varnish to primary teeth of all infants, children, starting at the age of primary tooth eruption, and at the age of six for children whose water supply is fluoride deficient in primary care practices.

Nevada Medicaid authorizes payment of diagnostic and preventive dental services for qualified recipients.

a. COVERAGE AND LIMITATIONS

Coverage is limited to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for persons less than 21 years of age. Coverage for persons over 21 years of age is limited to diagnostic services needed for emergency extractions or palliative care.

b. AUTHORIZATION REQUIREMENTS

No Prior Authorization (PA) is necessary for these services covered under EPSDT.

1003.2 RESTORATIVE DENTISTRY SERVICES (D2000-D2999)

The branch of dentistry used to restore the integrity of the teeth through the use of fillings or crowns.

Nevada Medicaid authorizes payment of restorative dentistry for qualified recipients.

a. COVERAGE AND LIMITATIONS

Restorative services are limited to EPSDT, for persons less than 21 years of age.

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For recipients age 21 years and older, with a prior authorization, Nevada Medicaid reimburses for certain fillings and crowns on teeth that are adjacent to a partial denture and are the abutment (anchor) tooth for that partial denture. Nevada Medicaid also reimburses for palliative treatment for persons 21 years of age and older. Pregnancy related services as defined in the MSM Addendum for persons 21 years of age and older are listed in the QIO-like vendor's web portal at www.medicaid.nv.gov in the Provider Type 22 Dentist Billing Guide.

Fillings are limited to the use of amalgam or plastic.

Crowns are limited to stainless steel and composite resin repairs.

b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT.

1003.3 ENDODONTIC SERVICES (D3000-D3999)

The branch of dentistry specializing in disease or injury that affects the root tips or nerves in the teeth through the use of root canals.

Nevada Medicaid authorizes payment of endodontics for qualified recipients.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT for persons less than 21 years of age.

b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT.

1003.4 PERIODONTIC SERVICES (D4000-D4999)

The branch of dentistry used to treat and prevent disease affecting supporting bones, ligaments and gums of the teeth.

Nevada Medicaid authorizes payment of periodontics for qualified recipients.

a. COVERAGE AND LIMITATION

1. Coverage is limited to EPSDT, for persons less than 21 years of age, or as palliative treatment (codes D4355 and D4999) for persons 21 years of age and older.

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2. Periodontal scaling and root planing for pregnant recipients is a covered service. Due to the risk of pregnancy gingivitis, Medicaid will cover a second cleaning during pregnancy as well as 100% coverage of the treatment of inflamed gums around wisdom teeth during pregnancy.

Medicaid carefully monitors for the appropriate use of codes D4341 and D4342. These codes are generally limited to recipients who are at least 14 years old. Providers' in-office records must verify x-rays, periodontal charting, and diagnoses documenting the need for these procedures.

b. AUTHORIZATION REQUIREMENTS

1. No PA is necessary under EPSDT.
2. Some codes require a PA for Pregnancy related services for persons age 21 and older.

Reference the Coverage, Limitations, and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

1003.5 PROSTHODONTICS SERVICES (D5000-D6999)

The branch of dentistry used to replace missing teeth or restore oral structure through the use of partials, dentures, etc.

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Emergency prosthetic repair refers to dental prosthetics that are rendered completely unserviceable. Loose dentures or dentures with broken/missing teeth do not meet the intent of the definition unless irritation is present and sufficiently documented. The dentist's in-office records must substantiate the emergency for the purposes of Medicaid post-payment utilization review and control.

a. COVERAGE AND LIMITATIONS

1. Partial dentures and full dentures may be provided when medically necessary to prevent the progression of weight loss and promote adequate mastication. Medicaid limits reimbursement of services to one new full or partial denture per five years. Given reasonable care and maintenance, prostheses should last five years. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service.

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2. Medicaid will pay for necessary emergency x-rays required to diagnose Medicaid covered removable prostheses. No PA is necessary for the initial emergency examination and x-rays. The dentist's office records must substantiate the recipient's medical necessity (e.g., x-ray evidence, reported significant loss of weight, sore and bleeding gums, painful mastication, etc.). Payment for the examination and x-rays may be withdrawn if post-payment reviews of in-office records do not substantiate the medical necessity. Payment for dentures or partials includes any adjustments or relines necessary for six months after the date of delivery.
3. A person qualifies for a partial denture with four or more missing teeth, if anterior to the second molar in the same arch, or the four or more missing teeth are unilaterally (on one side only) in sequence as in, "2, 3, 4 & 5." Medicaid does not allow unilateral partials except in the immediately preceding and following examples. In the following examples the person would be eligible for a partial because four teeth would be missing and the person would be expected to have difficulty with mastication: missing 18, 19, 20 and 28 or 29; or 18, 19, 20 and 21 (four teeth in a row). However, a person would not be eligible for a partial if missing 19, 20, and 31 or 32 because there are not enough teeth missing for significant difficulty with mastication.
4. Third molars are not replaceable as missing teeth nor are they considered in the qualification for payment of partial dentures. Second molars are replaceable as missing teeth with missing posteriors in the same quadrant as explained in the above examples. A flipper may be used as a temporary replacement for employment purposes when an anterior tooth is extracted. For healing purposes, a flipper may be used temporarily when the partial for an anterior tooth will not be available for greater than 3 months.
5. Employment required partials may be authorized for payment. A person may also qualify for a partial when missing any one of the six upper or lower anterior teeth (6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 or 27) when necessary for employment. A supportive written Division of Welfare and Supportive Services, New Employees of Nevada (NEON) report meets the employment verification requirement. The recipient must receive the report from the NEON program for the dentist's submission with his request. Without the NEON report, the fiscal agent returns requests for work-required partials. The fiscal agent forwards complete requests to the Medicaid Dental Consultant for a determination. The consultant may approve this service when accompanying documentation substantiates employment necessity.

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6. Requests to override the 5-year limitation on full and partial dentures will require a PA and will only be considered for the following exceptional circumstances:
- Dentures were stolen (requires a copy of the police report). Also, under consideration is if the theft is a repeatedly occurring event. The recipient must exercise reasonable care in maintaining the denture.
 - Dentures were lost in a house fire (requires a copy of the fire report or other notification documenting the fire such as a newspaper article).
 - Dentures were lost in a natural disaster (requires a copy of documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or any other documentation indicating that the recipient's residence was in the area affected by the natural disaster).
 - Dentures no longer fit due to a significant medical condition. Requires one letter from each of the recipient's physician/surgeon and dentist. Physician/surgeon documenting the supporting medical condition. The dentist stating that the existing denture cannot be made functional by adjusting or relining it and that new dentures will be functional. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.
 - Dentures could not be made functional by issuing dentist. Requires a letter from the recipient's new dentist, the recipient's physician/surgeon and the recipient. The physician/surgeon stating the medical necessity for the denture. The dentist stating that the existing denture cannot be made functional by adjusting or relining it and that the new denture will be functional. The recipient stating that they returned to the issuing dentist requesting the denture be made functional and the issuing dentist was unable to comply. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

Process to request an override based on the above exceptional circumstances requires PA, the provider must submit the following:

- A properly completed ADA claim form clearly marked "Request for Denture Override".
- Copies of current radiographs when requesting an override for a partial denture to a full denture.

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- h. Any supporting documentation listed in this section, as applicable.
- i. A cover letter that clearly describes the circumstances of the case.
- j. These requests must be mailed to Medicaid's QIO-like vendor's dental consultant.

7. Medicaid will pay for a maximum of one emergency denture reline and/or maximum of six adjustments done not more often than every six months, beginning six months after the date of partial/denture purchase. No prior approval is required for relines. The provider's in-office records must substantially document the medical emergency need. Denture/partial relines and adjustments required within the first six months are considered prepaid with Medicaid's payment for the prosthetic. Dentists should call or write to the fiscal agent to insure the reline is not being done within six months of the date of the last reline or new denture purchase. A claim submitted for a reline or adjustment sooner than six months since the last payment for a reline or adjustment will deny for payment. Post payment review will be done to assure that medical necessity of the service has been substantially documented.
8. If the recipient is unable to wear the denture, the recipient must schedule an appointment with the issuing dentist to have the denture/partial made functional. Factors which would cause the denture to not be functional would include improper fit, sore or bleeding gums and painful mastication. If the issuing dentist is unable to make the denture functional, resulting in the recipient requiring services from another dentist, a full or partial recoupment of payment may occur less the cost of the laboratory services. When the issuing dentist receives a recoupment notice the dentist must provide a copy of the invoice detailing the laboratory charges so that it may be deducted from the recoupment amount. The requirements in Section 1003.6 are applicable if a dentist requests a new denture within a five year period.

b. PROVIDER RESPONSIBILITY

1. New dentures or partials (or their replacements every five years) must be evaluated for medical necessity. Medicaid will not pay for routine examinations (code D0150) in connection with new dentures or denture replacements. For new dentures, dentists may bill code D0140 for the initial dental emergency and another code D0140 for the evaluation/provision of the dentures. Dentists may bill one examination charge at the time of the first visit. They may bill the other examination on the same service date used to bill the denture or partial. For replacement of full dentures the provider may not bill code D0140 a second time with the date of service used to bill the denture(s).

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2. Keep diagnosable, panoramic or full mouth x-rays as part of the dentist's record for all removable prosthetics. The x-rays and dentists office notes must substantiate all missing teeth.
3. The recipient must sign and date a delivery receipt to verify that the dentures/partials were received and are accepted and/or acceptable. The date of the signature on the delivery receipt must be the date the dentures/partials were received by the recipient. The delivery receipt must include the recipient's name, quantity, detailed description of the time(s) delivered and the date and time of delivery.

c. AUTHORIZATION REQUIREMENTS

1. PA is required for partials and/or full dentures for all recipients residing in Nursing Facilities or receiving Hospice services.
2. Requests for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services must explain the significance of all of the following qualifications of medical need:
 - a. The recipient's medical need for the service in considering his/her total medical condition. Requires one letter each from the recipient's primary care physician and dentist documenting the supporting medical condition.
 - b. Factors relating to conditions that hinder effective functioning, including but not limited to, impaired mastication, muscular dysfunction, type of diet, current weight compared to the previous year, diagnosis, ability to swallow and reason for poor nutrition. When documenting reason for poor nutrition, specify whether this is related to dental structures, or related to the recipients physical or medical condition and will not be improved with dentures.
 - c. Mental status relating to the recipients ability to understand the use and care of the partials and/or full dentures.
3. No PA is required for partials and/or full dentures for all other recipients. Post payment review will be completed at the discretion of the fiscal agent with recoupment of payment for any partials or full dentures not meeting the above policy for qualification of coverage.

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1003.6 DENTURE IDENTIFICATION IMBEDDING

Nevada Medicaid provides payment of denture identification imbedding for qualified recipients.

a. COVERAGE AND LIMITATIONS

Any removable prosthetic appliance paid for by the Nevada Medicaid program must have permanent identification labeling imbedded in it.

b. PROVIDER RESPONSIBILITY

Medicaid requires imbedding of the recipient's first initial, last name, and the last four digits of the social security number for complete dentures, partial dentures with acrylic saddles, and when relining unmarked appliances. Failure to include imbedding on prosthetic claims will result in nonpayment of dentures, partials, and relines. In cases of insufficient room, you may reduce the person's name and identifiers to the first and second initials, plus the last four digits of the social security number.

Code D5899 and descriptor "ID Imbedding" must be completed by delivery unless the prosthetics already show such markings and the provider so states. The fiscal agent will return all requests/billings for prosthetics, unless this requirement is met. If denture identification is impractical for another reason, the provider's written explanation will be evaluated by the QIO-like vendor's Dental Consultant for approval and exceptional processing.

c. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not require PA for ID imbedding.

1003.7 ORAL SURGERY (D7000-D7999)

The branch of dentistry using surgery to treat disorders/diseases of the mouth.

Nevada Medicaid authorizes payment of oral surgery for qualified recipients.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age, pregnant persons 21 years of age and older, and as palliative treatment for persons 21 years of age and older.

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b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT and for some pregnancy related services, or for persons 21 years of age and older, if the service is considered an emergency extraction or palliative care.

Reference the Coverage, Limitations, and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

1003.8 ORTHODONTICS (D8000-D8999)

The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function.

Nevada Medicaid authorizes payment for orthodontics for qualified recipients under 21 years of age.

The diagnostic codes D0330, D0350, and D0470 are considered to be "Orthodontia" services only when required for Orthodontia treatment prior authorization.

a. COVERAGE AND LIMITATIONS

Medicaid excludes orthodontic work, except that which is authorized by the Children with Special Health Care Needs Program and reimbursed by Medicaid, or when specifically authorized by Medicaid's QIO-like vendor dental consultant as medically necessary under EPSDT.

Panoramic films. After an initial panoramic film, additional x-rays of this type require PA, except in an emergency. Examples of emergencies include fractured jaw, unusual swelling, etc.

b. PROVIDER RESPONSIBILITY

1. Medicaid considers orthodontist billings for "Pre-orthodontic treatment visits" under code D8660 and related procedures. Medicaid will not reimburse billings for "pre-orthodontic treatment visits" under code D8660 and related procedures billed by general dentists. Only dentists with a specialty of orthodontia will be allowed to bill D8660 for reimbursement. A copy of the Client History Form must be completed by the recipient's treating general or pediatric dentist and submitted with the billing. Medicaid may deny orthodontist's payment for their billings if the attached referral report does not show the recipient has a good history of keeping appointments and complying with dental care treatment. Orthodontists should

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2. advise recipients to establish good compliance and appointment-keeping histories before requesting initial or subsequent orthodontic treatment.
3. Coordination with Ancillary Dentists: The orthodontist and any ancillary dentists must coordinate with each other to assure Medicaid will pay for the ancillary dental services. For example, the orthodontist's proposed treatment plan should show he/she will be referring the child for extractions or other services. The ancillary dentist need not obtain separate approval for his/her services.

c. AUTHORIZATION REQUIREMENTS

1. Medicaid dental consultants use the assistance of board-certified and/or board eligible orthodontists and other dentists for authorization decisions. Consultants may require documentation to substantiate their decisions.
2. Requests for orthodontia must explain the significance of one or more of the following considerations of "medical need":
 - a. Functional factors relating to conditions that hinder effective functioning, including, but not limited to, impaired mastication and muscular dysfunction.
 - b. Factors related to the degree of deformity and malformation which produce a psychological need for the procedure. The psychological need must be based on objective evidence and reviewed by the dental consultant.
 - c. The recipient's overall medical need for the service in light of his/her total medical condition. For example, an orthodontia need which might be slight in an otherwise healthy child may become quite severe for a child suffering from complicating ailments such as cerebral palsy or epilepsy.
 - d. The medical appropriateness of an orthodontic treatment plan as opposed to other available dental treatment. Appropriate consideration may be given, for example, to a child's inability to understand and follow a treatment plan where failure to follow the plan would result in medical complications of the child's condition.
 - e. A score of 26 or higher on the Handicapping Labiolingual Deviation Index (HLD). (form found at: www.medicaid.nv.gov)

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3. When the orthodontist has assured the above requirements are met, use a separate form to bill the following initial services: examination, diagnosis, diagnostic cast, panoramic x-rays and diagnostic films. These can be provided by a dentist or orthodontist according to services limitations.
The following documents are required to be attached with the prior authorization request to the QIO-like vendor's Dental Consultant:

- a. HLD Index Report Form.
- b. Client Treatment History Form.
- c. Statement addressing the diagnosis/treatment plan and prognosis.
- d. Any other documentation that may be required to substantiate prior authorization decision.

All forms are located on the QIO-like vendor's web portal at www.medicaid.nv.gov.

4. The Dental Consultant may require the orthodontist to shorten their treatment plan, periodically reviewing/determining the child's continuing need for active treatment and retention care.
5. All orthodontic treatment authorizations by Medicaid will be to specialists in orthodontia only. Medicaid approves interceptive orthodontia for general dentists and pediatric dentists only.
- a. Orthodontists must use one of the codes for "limited" or "comprehensive" orthodontic treatment for bills and payment PA requests. Coverage, Limitations, and Prior Authorization requirements document can be found on the QIO-like vendor's web portal at www.medicaid.nv.gov.
 - b. Use one of the "limited" codes whenever possible. The treating orthodontist should try to achieve tolerances below Medicaid's treatment-need criteria.
 - c. Failure to achieve sufficient results in the approved amount of time is sufficient for Medicaid to deny a treatment extension. Medicaid will definitely deny an extension if results are poor and the recipient has failed to keep appointments and comply with treatment.
 - d. PA submittals must show all procedures. List the following at a minimum; initial banding, months of treatment including retention treatments, and

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any retainers. Medicaid expects the provider to render unlisted but necessary treatment components at no additional charge. The provider's usual and customary charge must show for each service. Stating a total fee for all services is not acceptable.

6. For orthodontia approvals, a dental consultant will sign the returned request form and indicate the "Total amount" shown on the form. Medicaid's QIO-like vendor will keep a record of the approved payment amount and treatment plan. The fiscal agent will return denied orthodontia request forms to the provider.
7. When the provider begins the authorized work, he/she enters the service date and amount on the form, and returns it to the fiscal agent. The fiscal agent will make payment for the total specified on the approved treatment plan.
8. An orthodontist's acceptance of full payment is considered his/her agreement to prorate and forward payment to any orthodontist the recipient may select to complete the orthodontic treatment. The recipient may select a new orthodontist if the recipient becomes dissatisfied with the original orthodontist or must geographically move before finishing treatment. The orthodontist must refund any unused payment when the recipient fails to contact the orthodontist's office within a four month period. Also, the orthodontist must refund Medicaid if the recipient has not kept at least one appointment within a nine-month period.
9. Medicaid will adjust the sending provider's future payments if the Medicaid dental consultants determine the provider allotted an insufficient amount of money to the receiving provider or Medicaid.
10. Orthodontists may not assess the recipient for additional charges on broken bands and other necessary services, even if the recipient's poor compliance or carelessness caused the need for additional services. However, orthodontic providers may discontinue treatment due to poor recipient compliance, returning any unused prorated expenditures to Medicaid with a written explanation for the Medicaid fiscal agent's records.
11. Under no circumstances should the provider release Medicaid money to anyone other than another orthodontist provider who promises to use the money to complete the purchased treatment. Without such a promise, return the money to the QIO-like vendor at the address listed in the cross-reference of this chapter at Section 1005.1. Write refund checks payable to Nevada Medicaid.
12. Once the remaining portion of the payment is returned, no further payment can be made to complete care for recipients who have become ineligible. Most children who lose Medicaid coverage are seldom able to finance the completion of

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orthodontic care. Therefore, Medicaid understands and holds the refunding orthodontist responsible for removing any banding and providing retainers at no additional cost to the recipient. Orthodontists accept this responsibility as part of doing business with Medicaid.

1003.9 ADJUNCTIVE GENERAL SERVICES (D9000-D9999)

The branch of dentistry for unclassified treatment including palliative care and anesthesia.

Nevada Medicaid authorizes payment of adjunctive general services for qualified recipients under 21 years of age and for palliative care and anesthesia for persons 21 years of age and older.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age, and for palliative care for persons 21 years of age and older.

b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT. Persons 21 years of age and older require PA unless the service is for emergency extractions, palliative care, partials or dentures.

1003.10 PERSONS 21 YEARS OF AGE AND OLDER

Nevada Medicaid authorizes payment for qualified persons 21 years of age and older for partials, dentures, emergency extractions, and palliative care only.

a. COVERAGE AND LIMITATIONS

Reference Nevada Medicaid Fee Schedule, Coverage and Limitations and Prior Authorization document for Provider Type 22, can be found on the QIO-like vendor's web portal at www.medicaid.nv.gov.

b. PROVIDER RESPONSIBILITY

1. Providers must keep all substantiating x-rays on file for a minimum of six years following the date of service. Providers must keep the x-rays, related charting, and other case documentation easily available to Medicaid reviewers during this period.
2. The Medicaid program considers emergency extractions a program benefit without prior or post approval. This includes the use of in-office sedation or anesthesia. The program never covers extractions for cosmetic purposes. Dentists

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need not routinely submit substantiating x-rays to the Medicaid fiscal agent. However, Medicaid will periodically request copies of x-rays substantiating third molar extractions (teeth 1, 16, 17 and 32 for adults and children) related to tissue impaction, partial and full bony and surgical vs. simple extractions. The dentists on-file x-rays must reveal sufficient bone and root complications for difficult surgical removal procedures.

3. For treatment necessary to avoid life-threatening health complications, providers perform services necessary to prevent life-threatening deterioration of a person's physical health without PA even though the services do not immediately qualify as Medicaid covered emergency services. The dentist must certify the services were medically necessary due to health complicating conditions such as HIV, AIDS, cancer, bone marrow transplantation, or post kidney transplant. The dentist's certification must be part of a note explaining why the treatment was necessary to avoid life-threatening problems. For example, the dentist may explain successful cancer treatment or organ transplantation depended on extractions or treatment of caries to protect the recipient's compromised immune system from the stress of oral infection.

c. AUTHORIZATION REQUIREMENTS

No authorization is needed if the service is for emergency extraction or palliative care.

1003.11 SERVICES NOT COVERED BY MEDICAID

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not cover the following services:

1. Cosmetic services, unless prior approved by the QIO-like vendor's Dental Consultant to return the recipient to work.
2. Routine and preventive dental care, such as periodic prophylaxis, restoration of incipient or minor decay, treatment of sensitivity to hot and cold or other minor pain is not covered for persons 21 years of age and older. (Prophylaxes and restorative dental services under pregnancy related services require PA and reviewed on an individual basis based on medical necessity.)
3. Crowns are not allowed for persons 21 years of age and older, except where required on an anchor or abutment tooth for a partial denture. Gold crowns are not a covered benefit for any age.
4. TMJ services are not covered by Nevada Medicaid.

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5. No show appointments or charges for missed appointments are not allowed.

1003.12 PHARMACY SERVICES

Nevada Medicaid authorizes payment of pharmacy services for qualified recipients.

a. COVERAGE AND LIMITATIONS

Fluoride supplements are covered only for recipients less than 21 years old.

b. PROVIDER RESPONSIBILITY

Supplements need no PA when ordered by a dentist. The dentist should write, “Result of Healthy Kids” or “Result of EPSDT” on the prescription. The recipient must present the prescription with a Nevada Medicaid card to a Medicaid participating pharmacy provider. Providers must verify eligibility prior to service.

c. AUTHORIZATION PROCESS

These guidelines do not change any Medicaid policy regarding non-covered medications or medications which always require PA.

1003.13 RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Nevada Medicaid authorizes payment for services provided in an ICF/IID to full Medicaid-eligible recipients.

All dental services provided to recipients in an ICF/IID are administered under the same policy coverage and limitations provided throughout this dental chapter.

a. COVERAGE AND LIMITATIONS

Under Federal regulations, the ICF/IID is required to include comprehensive dental services to their resident. Specifically, the ICF/IID’s are responsible for:

1. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within 12 months before admission.
2. Periodic examination and diagnosis done at least annually for each recipient.

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3. Comprehensive dental treatment including dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.
4. Necessary access to the services, excluding sealants, orthodontia, pharmacy services, fluoride treatments, and fluoride treatments with prophylaxis.
5. Emergency dental treatment on a 24-hour-a-day basis by a qualified dentist.
6. If appropriate, the dentist's/hygienist's participation in development, review, and updating of the individual program plan as part of the Interdisciplinary Team (IDT) process, either in person or through written reports to the IDT.

For dental services beyond the Medicaid coverage benefit the facility must provide or make arrangements for each client from qualified personnel, including licensed dentists and dental hygienists to establish a relationship with the ICF/IID.

b. PROVIDER RESPONSIBILITY

For dental services beyond the Medicaid coverage benefit the dentist must establish a relationship with the ICF/IID facility staff to assure verification of the recipient's ICF/IID residency, and payment source for dental services prior to service.

1003.14 PROVIDERS OUTSIDE NEVADA

Nevada Medicaid authorizes payment for out-of-state providers under Medicaid guidelines.

a. COVERAGE AND LIMITATIONS

Out-of-state providers are subject to the coverage and limitations of dental services under Nevada Medicaid.

b. PROVIDER RESPONSIBILITY

Out-of-state providers are subject to all Medicaid rules and guidelines.

c. AUTHORIZATION REQUIREMENTS

Out-of-state providers must use the same PA process as in-state dental providers.

1003.15 PAYMENT OF NON-COVERED SERVICES

A. COVERAGE AND LIMITATIONS

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Nevada Medicaid does not authorize payment for non-covered services.

B. PROVIDER RESPONSIBILITY

Dental providers must inform the recipient of his/her financial responsibility before rendering any uncovered service. Consider this done when the recipient or a responsible designee signs a written document acknowledging acceptance of financial responsibility for each specific itemized service. The signed document must state, "I understand Medicaid will not cover the above itemized service cost(s). I agree to pay for the services."

If Medicaid covers a procedure, the provider cannot charge the recipient for the balance after Medicaid's payment. Also, providers cannot charge Medicaid for one covered service and provide a different service. For example, since Medicaid does not cover restorations or prosthetics made of gold, Medicaid's payment on a covered restoration or prosthesis cannot be used to offset one made of gold. The recipient would need to pay the complete charge for the gold restoration or prosthesis, or the recipient must accept the Medicaid benefit service only.

C. RECIPIENT RESPONSIBILITY

Services exceeding program limitations are not considered Medicaid benefits. These services are the financial responsibility of the recipient.

D. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not authorize payment for non-covered services.

1003.16 SERVICES PROVIDED IN NURSING FACILITIES

Nevada Medicaid authorizes payment for services provided in nursing facilities to qualified recipients eligible with full Medicaid benefits.

a. COVERAGE AND LIMITATIONS

All dental services provided to recipients in a nursing facility are administered under the same policy coverage and limitations provided throughout this dental chapter.

b. PROVIDER RESPONSIBILITY

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Medicaid advises dentists to confirm the recipient's eligibility through the Eligibility Verification System (EVS) for the month the service will be provided and retain a copy prior to service. Medicaid advises dentists to develop procedures with nursing facility staff to screen for ineligible recipients. Medicaid recommends dentists become users of EVS by making arrangements with Medicaid's QIO-like vendor.

c. NURSING FACILITY RESPONSIBILITY

Nursing facility staff must screen for Medicaid eligibility.

d. AUTHORIZATION REQUIREMENTS

NOTE: If the recipient is covered under Managed Care and has been an in-patient over 45 days, the recipient is then covered by fee-for-service from the 46th day forward.

PA is required for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services.

1003.17 HOSPITAL/SURGICAL CENTERS

A. COVERAGE AND LIMITATIONS

Nevada Medicaid authorizes payment for certain dental services in hospital or surgical centers for qualified recipients with PA unless it is an emergency.

B. AUTHORIZATION REQUIREMENTS

1. Two authorizations for inpatient hospitalization for a dental procedure are necessary for Medicaid reimbursement.

a. The dental consultant must prior authorize the dental procedure.

b. The Medicaid's QIO-like vendor or the Managed Care Organization (MCO) must certify the necessity for the recipient to be hospitalized for the performance of the inpatient dental procedure. The certification must be done before or on the date of the admission.

The provider must write, "Hospital Admission" at the top of the Examination and Treatment Plan box of the claim form.

2. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must write, "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

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- a. Specific authorization is not required for the anesthesiologist and/or outpatient facility for recipients less than 21 years of age.
- b. All dentists providing surgical center services to Medicaid recipients must retain in-office copies of x-rays, intra-oral preoperative photographs (when necessary), and documentation necessary to substantiate service need. The substantiating evidence must be retained and remain readily available for no less than six years. Medicaid holds the provider responsible for assuring the evidence is sufficient for the Medicaid agency's post utilization review/control purposes.
- c. In situations where the dentist believes his treatment plan to have weak support from x-rays, intra-oral photographs, etc., the dentist should submit the evidence with a request for PA. Without PA, Medicaid will reclaim payment for the services if post service review findings do not support the dentist's treatment plan and medical necessity.
- d. All outpatient facility services for Medicaid recipients 21 years of age and older must be prior authorized.
- e. Medicaid does not reimburse providers for travel and hospital call related costs for services done in an outpatient surgical center.

1003.18 MAXILLOFACIAL SURGERY AND OTHER PHYSICIAN SERVICES

Nevada Medicaid authorizes payment for maxillofacial surgery and other physician services for qualified recipients.

Temporomandibular Joint (TMJ) related disease encompasses a variety of conditions. For recipients, age 20 years and younger, TMJ services may be provided by a dentist or medical doctor. Adult dental services continue to be restricted to palliative treatment, emergency extractions and dentures/partial with PA.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age.

Coverage for the medical management of TMJ related disease for recipients, age 20 years and younger will be limited to appropriate current TMJ related diagnosis codes.

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The following CPT codes are covered for TMJ services for recipient's age 20 years and younger:

99241-99245 Office and Other Outpatient Consultations
21089 Prepare face/oral prosthesis
70328 X-ray exam of jaw joint
70330 X-ray exam of jaw joints
70336 Magnetic image, jaw joint
70355 Panoramic x-ray of jaws
76100 X-ray exam of body section

b. PROVIDER RESPONSIBILITY

Program utilization control requires that each type of provider (dentist, physician, pharmacist, etc.) be delineated with the use of a specific Provider Type number. For example, dentists are a Provider Type 22 while physicians are a Provider Type 20. All dental related services must be billed/requested with the most appropriate dental code found on the QIO-like vendor's web portal at www.medicaid.nv.gov. When the list of accepted dental codes provides only a "By Report" code, the provider must use the most appropriate "By Report" code. When an appropriate dental code is not available, a Current Procedural Terminology (CPT) code from range 10000 through 69999 and 99241 through 99245 may be used. A dentist, Provider Type 22, who is a dually boarded Maxillofacial Surgeon, may bill the following CPT codes in addition to those previously listed: 00190, 21085, 70250, 70300, 70328, 70330, 70350, 70355, 70380, and 99281 through 99285.

Fluoride varnish application which can be administered by Provider Types 17, 20, 24 and 77 should be billed on a CMS 1500 form using the most appropriate and available ICD diagnosis code.

c. AUTHORIZATION REQUIREMENTS

See B. Provider Responsibility.

1003.19 CONDITIONS FOR PARTICIPATION

All dental providers must have a current license to practice dentistry, dental surgery, or dental hygiene which has been issued by the Nevada State Board of Dental Examiners. Out of state dentists must meet the licensing requirements of the state in which they practice and be enrolled as a Nevada Medicaid provider.

Dental services may also be performed in a clinic setting as long as the care is furnished by or under the direction of a dentist. The clinic must have a dental administrator and all professional

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staff, dentists, hygienists, etc. must have a current Nevada license and/or certification from the appropriate state licensing board.

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1004 HEARINGS

Please reference Nevada Medicaid Services Manual, Chapter 3100, for Medicaid Hearing process.

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1005 REFERENCES AND CROSS REFERENCES/FORMS

Other sources which may impact the provision of Dental services include, but are not limited to the following:

Chapter 100: Eligibility Coverage and Limitations
Chapter 200: Hospital Services Program
Chapter 300: Diagnostic Testing and Radiology Services
Chapter 500: Nursing Facility
Chapter 600: Physician Services
Chapter 1200: Prescription Services (Rx)
Chapter 1500: Healthy Kids (EPSDT)
Chapter 1600: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Chapter 2100: Home and Community-Based Services Waiver (MR)
Chapter 3100: Fair Hearing Process

1005.1 CONTACTS

A. Nevada Medicaid Provider Support
Division of Health Care Financing and Policy
1100 East Williams Street
Carson City, NV 89701
(775) 684-3705
<https://dhcfp.nv.gov>

B. Hewlett Packard Enterprise Services
Customer Services Center
(For claim inquiries and general information)
(877) 638-3472
www.medicaid.nv.gov

Prior Authorization for Dental and Personal Care Aide
Attn: Dental PA
PO Box 30042
Reno, NV 89520-3042
(800) 525-2395 (Phone)
(855) 709-6848 (Fax)

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- D. Mail all paper claims (CMS 1500, UB-92, ADA, and Medicare Crossover) to the following address:

Quality Improvement Organization (QIO) – Claims
 (Include claims type e.g. CMS 1500, UB-92)
 P. O. Box 30042
 Reno, NV 89520-3042

1005.2 FORMS

- A. The ADA 2012 version is required for all prior authorization requests, claims, adjustments and voids.

1005.3 DENTAL PERIODICITY SCHEDULE

The recommended periodicity schedule can be found at <https://www.aap.org>.

REFERENCES:

- AAPD Recommendations for Pediatric Oral Health Care
- UNLV School of Dentistry Patient Oral Disease Preventative Studies/Protocol
- Counseling to Prevent Dental and Periodontal Disease, Guide to clinical preventive services, 2nd edition, Baltimore MD, Williams & Wilkins; 1996, 711-722, National Guideline Clearinghouse
- CMAJ March 1995, Prevention of Dental Caries, National Guideline Clearinghouse
- Larry Pierce, DDS
- Small Smiles Dentistry of Reno
- Bruce Dow, DDS